Addressing Sexuality and Pregnancy in Childbirth Education Classes

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ABSTRACT

A positive, nonjudgmental, and informed approach to sexual health during pregnancy promotes acceptance of the normal functioning of women's bodies. It also encourages the development of close and supportive relationships that are so essential during pregnancy and birth. Common concerns do not need to become problems. Concerns include issues of libido, positioning, and preterm labor or fetal health, as well as myths and cultural attitudes. Childbirth educators can use tools such as the PLISSIT model to approach the topic of sexuality during pregnancy. In addition, opportunities are available in every childbirth class to acknowledge or ignore sexual issues. Perinatal educators who take responsibility for addressing this often-taboo topic can enhance women's feelings of safety and their confidence in normal birth.

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READER'S QUESTION

What is a good way to educate pregnant women and their partners (the days when partners were husbands are long gone) about sex during pregnancy? I typically include brief information about sexuality during pregnancy in the childbirth classes that I teach. Basically, I just assure couples that continued sexual activity is safe during pregnancy. I only talk more about the topic if the class members ask questions or when individuals stay late or call me after class. Now, it appears that I have a lesbian couple in my class. I realize that I really don't know what to do. I think that I should address sexuality, but I do not feel that I know enough to be comfortable with the topic.

– An LCCE educator in North Carolina

COLUMNISTS' REPLY

It sounds like both you and the couples in your childbirth class may be afraid to talk about sexuality and pregnancy, but at least you are not afraid to ask about the topic. Your discomfort is not unique. In asking this question, you demonstrate your recognition that, as a professional health educator, the responsibility for assessing and addressing the need is yours. Knowledge about sexuality during pregnancy is critical for childbirth educators whose goals include supporting and promoting acceptance of the normal functioning of women's bodies, as well as developing supportive relationships that are so essential during pregnancy and birth (see Lewis & Black, 2006; Polomeno, 1999).

For centuries, the pregnant body has connoted ripeness, fruition, abundance, and wealth. One look at a statue of the Venus of Willendorf, with her protruding belly and full breasts, reveals that ancient cultures also perceived pregnancy as sexy. Yet, in our own modern culture, sexual expression during pregnancy is often considered a taboo subject and, when the topic is discussed, myths and misinformation about sex during pregnancy abound (Read, 2004). Concerns ranging from the belief that the unborn baby somehow knows sex is taking place to fears that intercourse will cause a miscarriage (March of Dimes, Pregnancy & Newborn Health Education Center, 2006) often go unanswered for pregnant women and their partners. These worries often impede what should be a natural, healthy part of pregnancy—sexual expression and lovemaking.

Barriers to Discussing Sex and Pregnancy

A discussion of how best to educate pregnant women and their partners about sex during pregnancy must begin with examining how perinatal educators and other health-care professionals handle the topic of sexuality when assessing and educating expectant women. According to Katz (2005a), research findings suggest that even nurses are inconsistent with providing information and counseling about sexual matters in general. Reasons for their inconsistency are embarrassment, discomfort with their own sexuality, fear that asking questions of a sexual nature is an invasion of patient privacy, and worries that questions about sexuality will be interpreted as a form of sexual harassment and lead to legal ramifications (Katz, 2005a). Another article by Katz (2005b) includes, as a barrier, the lack of education and training about sexuality: ''[Q]uestioning patients about sexual functioning is not taught as a routine part of the patient encounter and so may be forgotten'' (p. 240).

Pregnant women and their partners especially want and need information about sexuality. Studies have shown that most patients believe such discussions are appropriate; however, they feel more comfortable if the professional initiates the discussion (Katz, 2005b). In a childbirth education class, that professional is you.

Using the PLISSIT Model to Initiate Discussions

One tool that perinatal educators can use to initiate discussions about sexuality with expectant mothers is the PLISSIT model. PLISSIT is an acronym for Permission, Limited Information, Specific Suggestion, and Intensive Therapy. The model is the most frequently employed tool for assessing sexual functioning and can be used with anyone, including pregnant women (Alteneder & Hartzell, 1997; Katz, 2005a). The first step—permission—opens the door to a discussion by allowing the woman to discuss sexuality. For example, you might say to the expectant mother, ''Your body is going through so many changes right now, and some of those changes may affect your sexuality. Many women have questions about sex during pregnancy. Do you have any concerns you'd like to discuss?'' It is important to approach the topic of sexuality in a nonthreatening way in order for a woman (or class participants) to feel comfortable having the discussion (Katz, 2005a).

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To view images of the Venus of Willendorf, log on to www.google.com and type ''Venus Willendorf'' in the search bar.

The second step in the PLISSIT model—limited information—refers to giving the woman just enough information to help improve her sexual functioning (Katz, 2005a). For example, an expectant mother may ask if sexual intercourse will cause her to have a miscarriage. You can explain that intercourse does not cause miscarriage and that miscarriages, especially those that occur in the first trimester, are usually the result of a chromosomal abnormality or some other problem related to fetal development (Mayo Clinic Staff, 2006).

The third step in the PLISSIT model—specific suggestion—requires greater knowledge and expertise on the professional's part. For example, for an expectant mother with cervical or placental irregularities, you will need to provide sexual counseling or a referral specific to the mother's condition, instead of more general counseling (Mayo Clinic Staff, 2006).

It is important to acknowledge that the childbirth educator's expertise may be limited in providing specific information on issues related to sexuality. When this is the case, it is appropriate to suggest referrals to other health-care providers.

The final step in the PLISSIT model—intensive therapy—usually refers to conditions that require treatment by a physician, specialist, or therapist (Katz, 2005a). For example, a mother who continues to experience dyspareunia (painful intercourse) months after giving birth will need to be referred to a gynecologist or, perhaps, to a specially trained, woman's physical therapist.

Providing a Safe, Comfortable Setting for Sexuality Discussions

To further reduce barriers to communication about sexuality, you may need to provide a quiet, private place after class in which to initiate the discussion. Some pregnant women are embarrassed by questions concerning sexuality and will not want to have such discussions in front of others.

You should also be mindful of cultural differences in attitudes toward sexuality. For example, Latina women usually feel more relaxed and comfortable with a discussion about sexual matters after some rapport has been developed (Katz, 2005a). Therefore, the first class may not be the best time to introduce this topic in your curriculum. Plan to give your couples a little time to get acquainted first.

Creating a Nonjudgmental Approach to Sexual Orientation

You mentioned that you think an expectant mother in your class is a lesbian. That appears to create a barrier to communication for you. I suggest that you (and all health professionals) need to take time to examine your own biases and beliefs, including those about sexual orientation. Perinatal educators and other health-care providers should avoid judgmental attitudes about their clients, including gender orientation and other sexual issues. This is critical in order to create an environment where expectant women, including pregnant lesbians, feel comfortable discussing their sexual concerns.

Regardless of their own beliefs, educators also need to recognize that the number of lesbians choosing to have children has increased. It is estimated that 6–14 million children in the United States have gay or lesbian parents (Mravcak, 2006). Many lesbians who decide to become pregnant are over the age of 30 years old; thus, they may have age-related concerns about their pregnancies (Hughes & Evans, 2003). Evidence suggests that, when a woman identifies herself as a lesbian, many health-care providers make the erroneous assumption that her reproductive history is irrelevant (Marrazzo & Stine, 2004). Perinatal educators and other providers must recognize that the pregnant woman they help may, indeed, be a lesbian and that her concerns about sexuality are every bit as important as the concerns of her heterosexual counterparts.

Addressing Concerns About Sex During Pregnancy

Regardless of her sexual orientation, the pregnant woman may have many concerns about sex and sexuality that should be addressed by an educator, nurse, or other health-care provider. A woman's burgeoning body may affect her feelings about her sexual self. Some women feel unattractive and, therefore, sexually undesirable during pregnancy, while others find their more voluptuous physique makes them feel sexier (Read, 2004). Sexual problems may be psychological in nature or related to concerns about intercourse harming the baby or about orgasm resulting in premature labor. Women who have undergone infertility treatments or have had previous miscarriages, an abnormal fetus, or neonatal death may be extremely anxious and, thus, need additional support and reassurance (Read, 2004). Conditions exist in which the pregnant woman may be advised to abstain from intercourse. These conditions include vaginal bleeding, placenta previa, premature dilatation of the cervix, rupture of the membranes, a history of premature delivery, and multiple gestations (Read, 2004). Regardless of the concerns, using the PLISSIT model can help ease the discomfort of a sexual discussion and facilitate rapport between the expectant mother and educator.

In general, if a woman has a normal, uncomplicated pregnancy, she can be advised that sexual intercourse and orgasm are not contraindicated (Lowdermilk & Perry, 2004) Pregnant women and their partners should be counseled that intercourse will not harm the baby, as you say you have advised your class members in the past. You can integrate the subject of sex and pregnancy with other class activities without presenting sex as a separate topic. For example, when you teach your classes about the anatomy of pregnancy, you can make it clear that the male's penis does not come in contact with the fetus during sexual activity because the amniotic fluid in the uterus protects the fetus from the physical movements that occur during intercourse. You can also reassure class members that the mucus plug, which blocks the cervical opening, prevents bacteria and semen from entering the uterus (Fountain, 2007).

Pregnant women should be informed that most research has found that orgasms do not lead to premature labor or premature birth in normal pregnancies, including orgasms resulting from masturbation and oral sex (Mayo Clinic Staff, 2006). Both oral and anal sex are safe, as long as the woman is in a monogamous relationship with an HIV/STD-negative partner. If the expectant mother does not know her partner's HIV/STD status, she

should be counseled to use a dental dam (a piece of latex placed between the woman's genitals and her partner's mouth) when having oral sex (Centers for Disease Conrol and Prevention, 2000) and latex or polyurethane condoms when having anal or penile-vaginal sex. If the expectant mother and her partner engage in and enjoy anal sex, the couple should be counseled to proceed slowly and make sure that the anal sphincter is relaxed before penetration in order to avoid tearing sensitive skin (Plumbo, n.d.).

You may also explain to the expectant mother and her partner that fluctuations in sexual desire are perfectly normal during pregnancy. As a woman's body undergoes pregnancy-related changes, sex may feel more or less pleasurable. Many pregnant women have a decreased libido during pregnancy (Hyde, DeLamater, Plant, & Byrd, 1996). As breasts become enlarged and tender during pregnancy, they may feel painful when fondled. Engorgement of the genitalia due to increased blood flow in the pelvic region can lead to heightened pleasure in some women, while others may experience discomfort and a feeling of fullness. Increased vaginal secretions can either make sex more pleasurable or irritate the vagina. Some women also have abdominal cramping during or after sex, which may be uncomfortable or even painful (Lowdermilk & Perry, 2004). All of these conditions are normal, and you can counsel your class participants that most couples resume an active sex life within the first year of their baby's birth (March of Dimes, Pregnancy & Newborn Health Education Center, 2006).

Pregnant women and their partners often want advice about the most comfortable sexual positions. You can counsel expectant and new parents to experiment with a number of positions. Some examples include the woman lying sideways, so the partner keeps most of his weight off of her uterus; the woman situated on top, so she can control the depth of penetration and keep her partner's weight off her tummy; and the spooning position, which allows for shallow penetration when deep penetration may be uncomfortable (Lowdermilk & Perry, 2004).

You can also point out that there is more to sex and sexual expression than intercourse. The couples may find a great deal of intimate satisfaction in cuddling, kissing, fondling, and holding hands with each other. Massage or a warm bath together, along with soft music and candlelight, can help keep intimacy and romance alive during pregnancy.

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Establishing Good Communication

The key to maintaining healthy sexual functioning during pregnancy is good communication between the woman and her partner. Pregnant women can be encouraged to talk to their partners about the changes they are going through and about their intimacy needs. It is equally important for the partner to share his or her concerns about sexuality during pregnancy. Through efforts at good communication—in an open, honest, and loving way—misunderstandings can be avoided and the sexual health of the couple can be preserved (Lowdermilk & Perry, 2004).

Most important, fostering communication and a constructive attitude toward these normal functions of a woman's body help to support a positive view of the most incredible, normal biological function that a woman has: birthing and nurturing a child from her own body. Openness, acceptance, and evidence-based information about sexual health are keys to helping women feel safe with you, their bodies, their partners, and birth.

NOTE TO READERS

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